REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
20170629	[redacted]-1769

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
ISAACS WILLIAM ANDREW	3415 CHELSEA ST ORLANDO, FL 32803-0000	[redacted]-6969

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY (X one or more)	b. ETHNIC CATEGORY
CIVILIAN	19991214	(17)	[ ] Female [X] Male	[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [X] White [ ] Native Hawaiian or Other Pacific Islander	[ ] Hispanic/Latino [X] Not Hispanic/Latino

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
0	0	DN	

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
[ ] Army [ ] Coast Guard [X] Navy [ ] Marine Corps [ ] Air Force	[X] Active Duty [ ] Reserve [ ] National Guard	[X] Enlistment [ ] Medical Board [ ] Other [ ] Commission [ ] Retirement [ ] Retention [ ] U.S. Service Academy [ ] Separation [ ] ROTC Scholarship Program	JACKSONVILLE MEPS 7178 Baymeadows Way Jacksonville, FL 32256-7299

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp	✓		
18. Nose	✓		
19. Sinuses	✓		
20. Mouth and throat	✓		
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*	✓		
22. Drums *(Perforation)*	✓		
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*	✓		
24. Ophthalmoscopic	✓		
25. Pupils *(Equality and reaction)*	✓		
26. Ocular motility *(Associated parallel movements, nystagmus)*	✓		
27. Heart *(Thrust, size, rhythm, sounds)*	✓		
28. Lungs and chest *(Include breasts)*	✓		
29. Vascular system *(Varicosities, etc.)*	✓		
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*	✓		
31. Abdomen and viscera *(Include hernia)*	✓		
32. External genitalia *(Genitourinary)*	✓		
33. Upper extremities	✓		
34. Lower extremities *(Except feet)*	✓		
35. Feet *(See Item 35 Continued)*	✓		
36. Spine, other musculoskeletal	✓		
37. Identifying body marks, scars, tattoos	✓		
38. Skin, lymphatics	✓		
39. Neurologic	✓		
40. Psychiatric *(Specify any personality deviation)*	✓		
41. Pelvic *(Females only)*	NA		
42. Endocrine	✓		

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If abnormality noted, explain in Item 44.)*
[✓] Acceptable
[ ] Not Acceptable Class_____

35. FEET *(Continued) (Circle category)*
N - Normal Arch
C - Pes Cavus
P - Pes Planus
1 - Mild
2 - Moderate
3 - Severe
A - Asymptomatic
S - Symptomatic

FOR OFFICIAL USE ONLY

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LABORATORY FINDINGS

45. URINALYSIS	46. URINE HCG	47. H/H	48. BLOOD TYPE
a. Albumin: NEG-URISTIX b. Sugar: NEG-URISTIX			

TESTS	RESULTS			
	FIRST TEST	CODE	SECOND TEST	CODE
49. HIV	Neg SE223	DB		
50. DRUGS	Neg	N		
51. ALCOHOL				
52. OTHER				
a. PAP SMEAR				
b. EKG				
c. CXR				

[redacted]1769
25215568 Initial:
20170629 (YYYYMMDD)

SECOND SPECIMEN ID LABEL

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55.a. MIN WGT - MAX WGT	55.b. ACTUAL BF % - MAX BF %	56. TEMPERATURE	57. PULSE
70.25	183 lbs.	- 196	-		80

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST:	
a. 1ST	b. 2ND	c. 3RD		a. COLOR HAIR	b. COLOR EYES
SYS. 119	SYS.	SYS.		Brown	Right: Blue Left: Blue
DIAS. 69	DIAS.	DIAS.			

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/20 Corr. to 20/	By S. CX	Right 20/20 Corr. to 20/ by
Left 20/20 Corr. to 20/	By S. CX	Left 20/20 Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP PASS /14	Uncorrected PASS	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER — Unit Serial Number 64358 — Date Calibrated *(YYYYMMDD)* 20160728

HZ	500	1000	2000	3000	4000	6000
Right	05	00	00	00	00	00
Left	05	00	00	00	00	00

71b. Unit Serial Number — Date Calibrated *(YYYYMMDD)*

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

72a. READING ALOUD TEST — SAT UNSAT

72b. VALSALVA — SAT UNSAT

73. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY *(Use additional sheets if necessary.)*

61-66 Deanle
67, Deanle
70,
71,

Date of test: JUN 29 2017						
DRUG RESULTS						Initials
N	N	N	N	N	N	
Date of result: JUL 03 2017						

I acknowledge that I have read the MEPS Physical Examination Information sheet, confirm that I understand the content and consent to undergo the examination

Date 20170629
Applicant Printed name William Andrew Isaacs
Applicant Signature William Andrew Isaacs 20170629
Chaperone Printed Name
Chaperone Signature

APPLICANT HAS BEEN COUNSELED AND EVALUATED FOR SYNCOPE RISK.

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74.a. EXAMINEE/APPLICANT *(check one)*

- [x] IS QUALIFIED FOR SERVICE IN SPF DNR
- [ ] IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition. I have been advised to see my private medical care provider within 24-48-72 hours/30 days / Routine Follow-up (circle one) for further evaluation and/or treatment.

a. SIGNATURE OF EXAMINEE | b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*
1	1	1	1	1	1			JUN 2 9 2017

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED SERVICE	WAIVER RECEIVED DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)(Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL
1	P	JUN 2 9 2017	[illegible]				

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER: Patrick J. Ivory, PA-C 20170629 | b. SIGNATURE: JUN 2 9 2017

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER: Patrick J. Ivory, PA-C 20170629 | b. SIGNATURE: JUN 2 9 2017

83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)* | b. SIGNATURE

84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY: L.W. SHIVERTAKER, ME | b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE | b. GRADE | c. DATE *(YYYYMMDD)*: JUN 2 9 2017

86. WAIVER GRANTED *(If yes, date and by whom)*

- [ ] YES
- [ ] NO

87. NUMBER OF ATTACHED SHEETS: 0

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88. Additional Remarks (extension of blocks 77 or 78).